APPLICATION PROCESS
(Health Professionals)

Health Professional Applicants must meet the following conditions:

- Be a clinician practicing in an eligible specialty with United States citizenship or a legal permanent resident of the United States or be a selected refugee approved by the U.S. Attorney General;
- Be committed to providing full-time patient care (minimum of 40 hours a week, not including time on-call or travel time, except in those instances where the clinician is providing full-time care to low income, homebound patients in an underserved area and for whom transportation to the clinician's office is either unavailable or unreliable) for a minimum of two (2) years in an underserved area;
- Establish residency within 30 minutes of the practice site or, in the case of physicians, meet the requirement of the hospital in the catchments areas for admitting privileges;
- Have a valid, unrestricted license to practice medicine in the State of Delaware at the time the service obligation begins;
- Have not been convicted of any felony, including but not limited to violent felonies, as so defined under either Federal or State law and as more particularly defined and enumerated in 11 **Del. C.** Sec. 4201;
- Have not been convicted or found guilty of, or disciplined by this or any other State licensing Board or Agency authorized to issue a certificate to practice medicine or dentistry in this or any other State, for unprofessional conduct as so defined in 24 **Del. C.** Sec. 1731(a). Such a bar to applying for the Delaware State Loan Repayment Program For Health Professionals shall occur if the applicant was disciplined by means of levying a fine or by the restriction, suspension or revocation, either permanently or temporarily, of the applicant's certificate to practice medicine or dentistry, or by other appropriate action, which may include a requirement that the applicant who was disciplined must also complete specified continuing professional education courses;
- Have outstanding qualifying higher education loans that are not in default;
- **All <u>dentists</u>** must agree that a minimum of 20% of their scheduled appointments will be comprised of Medicaid patients and/or low-income (<200 FPL) dentally uninsured patients who will be provided care at reduced rates or free-of-charge. Low-income patients may include participants in the Nemours Dental Outreach program and the Vocational Rehabilitation program administered through the Delaware Division of Public Health.
- **All <u>non-dental clinicians</u>** must agree to participate in the Delaware Community Healthcare Access Program (CHAP) and the Voluntary Initiative Program Phase II (VIP II) sponsored by the Medical Society of Delaware. CHAP provides low cost or no cost primary care "medical homes" to individuals who are ineligible for the Diamond State Health Plan or the Delaware Healthy Children Program, yet within established income limits. Enrollment in CHAP also provides eligible individuals with access to a statewide network of medical subspecialty services. Other benefits currently under negotiation include discounted lab and x-ray services, and pharmaceuticals. CHAP recipients receive discounted medical services based upon their income. VIP II is a statewide network of private physicians who accept CHAP patients into their practices and serve as their health home or provide medical subspecialty services. To enroll in VIP II, call Wheeler & Associates at (302) 335-1560.

The Loan Repayment Health Professional Application must, at a minimum, include the following:

A. Clinician Data Form:

The Clinician Data Form must be completed and have attached the following:

- Copy of the Loan Repayment applicant's curriculum vitae; and
- Evidence of a Delaware license or certification or application for such.

B. Employment Contract:

Self-employed and/or solo practitioners do not need to submit an employment contract. However, self-employed clinicians must clearly demonstrate their fiscal and administrative capacity to operate a medical practice.

A non self-employed clinician must enter into an employment contract with a practice site, which must, at a minimum, include the following:

- Name and address of the practice site located in the underserved area, as identified by DHCC, at which the clinician will provide medical services. If the Loan Repayment Clinician will practice at more than one site, include the days and hours of practice at each site and a breakdown in the amount of time the clinician will practice at each;
- A statement that the practice site will employ the clinician on a full-time basis (minimum of 40 hours per week), not including time spent in travel and/or on-call);
- Description of the Loan Repayment Clinician's qualifications, proposed responsibilities and how his/her employment will meet currently unmet health care needs of a medically underserved community;
- If the Loan Repayment Clinician will be practicing in a medically underserved area as identified by DHCC that is based on a population group, the employer must provide adequate documentation of the care that will be provided to this group; and
- Certification that the Loan Repayment Clinician will provide health care services to Medicare, Medicaid and uninsured patients; and certification that all Physicians and the sponsoring physicians of a Physician Assistant will participate in the Voluntary Initiative Program (VIP II).

C. Loan Information and Verification Form:

The Loan Repayment Clinician must include a notarized 'Loan Information and Verification Form.' The document must contain the applicant's live, notarized signature (in blue ink).

D. Health Professional Loan Repayment Program Contract:

The health professional must enter into a contract with the State of Delaware committing to comply with all program requirements, including the following:

- Practice full-time in the approved underserved area for a minimum of two (2) years;
- Notify DHCC in writing within 30 days prior of any contractual changes that result in termination of contract, change in practice scope, and/or relocation from a practice site approved in the application request;

- Request any move to a different practice site than that already approved in writing to DHCC at least thirty (30) days prior to the change. Requests to change location of practice will be reevaluated based on eligibility criterion and service area priorities; and
- Report all changes in practice location and/or scope as well as routine correspondence to the following:

    Loan Repayment Coordinator
    Delaware Health Care Commission
    Haslet Armory Suite 202
    122 William Penn Street
    Dover, DE 19901
    Phone: (302) 672-5187
    Fax: (302) 739-6927

APPENDIX B

DELAWARE LOAN REPAYMENT PROGRAM
HEALTH PROFESSIONAL APPLICATION FORM

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1. Full Name: _____ Date of Application: _____

2. Date of Birth: _____ Place of Birth: _____

3. Social Security Number: _____ - _____ - _____

4. US Citizen: ☐ Yes OR ☐ No

5. Present Home Address: _____

_____

_____

6. Home Telephone: ( ) _____

Business Telephone: ( ) _____

7. Name of desired Practice Site, if applicable _____

Address:

_____

8. Discipline: Indicate the specialty you're interested in practicing and, if applicable, subspecialties and the percent of time devoted to each**.**

		Specialty
_____	Primary Care- MD	_____
_____	Primary Care- DO	_____
_____	Medical Oncologist	_____
_____	Pediatric Psychiatrist	_____
_____	Dentist - DMD	_____
_____	Dentist - DDS	_____
_____	Dental Hygienist	_____
_____	Certified Nurse Midwife	_____
_____	Physicians Assistant	_____
_____	Certified Nurse Practitioners	_____
_____	Clinical/Counseling Psychologist	_____
_____	Licensed Clinical Social Worker	_____
_____	Psychiatric Nurse Specialists	_____
_____	Licensed Professional Mental Health Counselor	_____
_____	Licensed Marriage & Family Therapist	_____

9. Proposed Service Commitment:

Participation in the Delaware Loan Repayment Program requires a minimum of two (2) years continuous full-time service. The maximum length of an initial contract is three (3) years. Please indicate the proposed length of your service commitment.

_____ Two (2) Years
_____ Three (3) Years

10. License:

Type: _____

State: _____ Number: _____

Date Issued: _____ Expiration Date: _____

Restrictions: _____

Has your license ever been suspended or revoked? * ☐ Yes ☐ No

Are any professional disciplinary actions pending? * ☐ Yes ☐ No

Have you ever been convicted of or pled guilty to a felony as so defined under either Federal or State law and as more particularly enumerated in 11 Del. C. Sec. 4201? * ☐ Yes ☐ No

*If you answered yes to either of the above questions, please attach an explanation to this application.

Are You Board Eligible? ☐ Yes ☐ No

Are You Board Certified? ☐ Yes ☐ No

Date of Certification _____

Name of Board: _____

Sub-Specialty Board: _____

11. Education (Please use additional paper as necessary)

College/Program: _____

Address: _____

_____

From: _____ To: _____

Degree/Diploma: _____ Discipline: _____

Contact Person: _____

Telephone: ( ) _____

Graduate School: _____

Address: _____

_____

From: _____ To: _____

Degree/Diploma: _____ Discipline: _____

Contact Person: _____

Telephone: ( ) _____

Medical or Dental School: _____

Address: _____

_____

From: _____ To: _____

Degree/Diploma: _____ Discipline: _____

Contact Person: _____

Telephone: ( ) _____

12. **Residency Program**:

Please list the information for the residency program most recently completed. If you have completed several residencies, or if your postgraduate training was completed through several programs, attach the required information for these programs to the application.

Residency: _____

Address: _____

_____

From: _____ To: _____

Degree/Diploma: _____ Discipline: _____

Contact Person: _____

Telephone: ( ) _____

Please indicate if your education, employment or licensure records are under another name(s):

_____ _____

Name Name

13. Program Eligibility (Please use additional paper if needed):

Do you have an existing service obligation due to any educational loans received? ☐ Yes ☐ No

If yes, please provide the following information.

Program Name: _____

Address: _____

_____

Contact Person: _____

Telephone: ( ) _____

When will this obligation be complete? _____

Do you have a current legal obligation to pay child support? ☐ Yes ☐ No

If yes, please provide the following information:

Name of child:

Name and address of person/agency payment is mailed to:

Telephone number of person/agency payment is mailed to:

When will this obligation be complete?

14. Describe your education and practice experience, which you believe qualifies you to participate in the Delaware Loan Repayment Program. Attach a one or two page description to this application that specifically includes the following:

- Training and experience and commitment to providing services to underserved and vulnerable populations;
- Practice experience in shortage areas;
- Personal origins or other factors that describe your commitment to practice in a shortage area and/or to serve vulnerable populations;
- Service awards received during your education or practice;
- Pre-professional experiences which caused you to decide to practice in a shortage area; and
- Physicians and dentists should discuss their collaborative practice experience and commitment to working with physician assistants, certified registered nurse practitioners, dental hygienists, and other practitioner disciplines.

Selecting a practice opportunity is a very important decision. The following questions, along with those above, are designed to assist in making compatible matches between applicants and applicant practice sites and the patient population.

15. Language(s) Spoken Fluently

☐ English
☐ Spanish
☐ Arabic
☐ French
☐ German
☐ Other (please specify) _____

16. Race/Ethnicity (collected for workforce research purposes only)

- ☐ Black, not of Hispanic origin
- ☐ Hispanic
- ☐ White
- ☐ Asian
- ☐ American Indian
- ☐ Pacific Islander
- ☐ Other (please specify _____)

17. Geographical Area(s) or Origin

Are you a native of a rural or urban underserved area, or have you spent a significant amount of time living or working in such an area?

- ☐ Yes (If yes, please elaborate.)
- ☐ No

18. Geographical Area(s) of Interest

Rate the area(s) of Delaware in which you would consider working with one (1) being your first choice and five (5) being your last.

_____ New Castle County – Northern
_____ New Castle County – Southern
_____ Kent County
_____ Sussex – Eastern (Coastal/Resort area)
_____ Sussex – Western

Rate the areas in which you would consider working with one (1) being your first choice and three (3) being your last.

_____ Urban
_____ Suburban
_____ Rural

19. Other Considerations/Comments:

Please discuss any preferences and/or requirements that you or your family members have regarding such factors as proximity to recreation, special interests or social activities, availability of other work/training opportunities (i.e. for your spouse/significant other); proximity to schools, etc. Use additional paper if necessary.

20. What date are you available for service? _____

21. How did you hear about the Delaware State Loan Repayment Program? _____

_____

22. Certification:

I certify that the information provided in this application packet is accurate and complete to the best of my knowledge. I hereby authorize DHCC to contact references and program directors listed in the application for the purposes of obtaining information about my professional qualifications, experience, abilities, and criminal history background. I understand that information I have provided is subject to verification.

_____ _____

Signature of Loan Repayment Applicant **Date**

APPENDIX C

DELAWARE LOAN INFORMATION AND VERIFICATION FORM

The following information must be provided for each loan that you are applying to have repaid under the Delaware Loan Repayment Program. **APPLICANTS**: Please complete PART A and then submit PART B to your lenders directly for verification. The Delaware State Loan Repayment Program is not responsible for submitting PART B to your lender.

PART A – TO BE COMPLETED BY APPLICANT

Name of Lending Institution and/or Federal, State or Other Government Program:

_____

_____

Street City State Zip Code

Date of Loan: _____ Account Number: _____

Original Amount of Loan: $ _____ Number of Payments Made: _____

Current Balance: $ _____ Date of Balance: _____

Payment Amount: $ _____ Interest Rate Compounded or Simple: _____

Purpose of Loan (as indicated on loan application): _____

_____

Any loan eligible for federal loan consolidation is eligible for repayment if obtained for the purpose of meeting the borrower's direct costs of attending undergraduate or graduate school, a school of medicine, or a school or osteopathy. Direct education costs include tuition, fees, books and supplies, living expenses, and other items normally associated with the cost of attendance for one academic year as defined by the U.S. Department of Education's Student Aid Handbook. Loans not eligible for federal loan consolidation will be considered if documentation is presented that establishes the proceeds from the loans were used to meet direct education costs. Credit card debt and funds received from the Delaware Institute for Medical Education and Research (DIMER) are ineligible for repayment. The Delaware Loan Repayment Program will only pay toward the educational costs associated with one health professional degree, and a determination will be made of the proportion of a consolidation loan that will be paid for successful applicants.

Copy of Loan Agreement Attached:	☐ Yes	☐ No
Copy of Loan Application(s) Attached:	☐ Yes	☐ No
Copy of Appropriate Consolidated Loan Documents Attached:	☐ Yes	☐ No

Dear Lender(s): (Retain a copy of this form as record of advanced payment request)
I am requesting that your institution submit the information requested as soon as possible to: Sarah McCloskey, Haslet Armory Suite 202; 122 William Penn Street, Dover, DE 19901. You may contact Ms. McCloskey by calling (302) 672-5187.

CERTIFICATION:
I hereby certify to the accuracy of the above information and apply to enter into an agreement with the Delaware Loan Repayment Program for repayment of educational loans, incurred solely for the costs of education at an undergraduate or graduate school, a school of medicine, or a school of osteopathy (for tuition, educational expenses or living expenses from a college, university, government or commercial source). I hereby authorize the financial institution or Government named in item 1 above to release this information about the loan listed in item 1 above to the administrator of the Delaware Loan Repayment Program.

Warning: any person who knowingly makes a false statement or misrepresentation in this loan repayment transaction, bribes or attempts to bribe a federal or state official, fraudulently obtains repayment for a loan under this agreement or commits any other illegal action in connection with this transaction may be subject to a fine or imprisonment under federal statute. I have read this statement and understand its contents.

SIGNATURE OF LOAN REPAYMENT APPLICANT **DATE**

PART B – APPLICANT SHOUD SUBMIT TO LENDER FOR VERIFICATION

The individual identified on this form has applied to participate in the Delaware Loan Repayment Program. The Delaware Loan Repayment Program is a program designed to improve the recruitment and retention of health care providers in underserved areas of Delaware. The individual identified above states that, to the best of his or her knowledge, the loan information provided is a bona fide legally enforceable commercial, federal, state, or other government educational loan obtained for the purpose of meeting the borrower's costs of attending undergraduate or graduate school, a school of medicine, or a school of osteopathy (for tuition, educational expenses or living expenses from a college, university, government or commercial source). Please verify the information according to your records and indicate any corrections in the "comment" space provided below. Also, please indicate your title and date this form in the spaces provided.

COMMENTS:

I hereby certify to the accuracy of the loan information contained on this Loan Information and Verification Form, or as corrected by my notations or comments:

Signature: _____ Title: _____ Date: _____
Lending Institution Representative

Address: _____ Telephone: _____

_____ E-Mail Address: _____

Delaware Institute for Dental Education and Research
Delaware Institute for Medical Education and Research
Delaware Health Care Commission
Delaware Higher Education Commission

Request to Release
Personally Identifiable and Confidential Information

The Family Educational Rights and Privacy Act (FERPA) allows institutions of higher education, state education agencies, and other agencies administering student aid programs to release detailed information to only the student. The student may; however, voluntarily waive their privacy rights to the person(s) they choose to authorize in the statement below. By completing this form the named person(s) will have the ability to obtain information regarding the student's financial aid and/or student loan files.

I _____ hereby waive my rights under the Family Educational Rights and Privacy Act (FERPA) by authorizing the Delaware Health Care Commission and Delaware Higher Education Commission, acting as agents for the Delaware Institute for Medical Education and Research to receive any requested information concerning my financial aid application, or application(s) for student loans, and other "non-directory" information pertinent to my application for the Delaware State Loan Repayment Program for Health Care Providers. The institutions and agencies directed to release information to the State's agents are listed below:

Health Professions Educational Institutions:

1. _____
2. _____

Lenders/Guaranty Agencies/Loan Servicers:

1. _____
2. _____
3. _____
4. _____

Student's Signature:_____

Social Security Number:_____

Date:_____